rate of reimbursement shall be based upon comparable and appropriate cost information which is available. Comparable rate and cost data shall be selected and combined in such a manner that the rate is reasonably expected to approximate median audited facility costs, had accurate cost reports been available for the particular class of facility. Such factors as mandated staffing levels and salary levels in comparable facilities shall be taken into account. This method of rate-setting shall ordinarily be relied upon to set rates only until such time as accurate cost reports which are representative of ongoing operations become available.

B. When it is determined that cost report data from a class of facilities is not reliable for rate-setting purposes due to inaccuracies or reporting errors, a random sample of such facilities shall be selected for audit and the resulting audited costs shall be used for the rate study.

C. After five years from the end of the fiscal year in which a facility begins participating in a program for Medi-Cal reimbursement, the reimbursement rate methodology will either revert to the provisions described in Section I through IV of Attachment 4.19-D or be subject to new provisions as described in a State Plan amendment.

VI. (RESERVED)

VII. PUBLIC CONSIDERATION

A. A public comment period is provided, during which a public hearing may be requested by interested parties. During this period, the evidentiary base and a report of the study methodology and findings are available to the public.

1. Interested parties will be notified of the time and place of the hearing (if scheduled), and the availability of proposed rates and methodologies by direct mail and public advertising in accordance with state and federal law.

2. Comments, recommendations, and supporting data will be received during the public comment period and considered by the Department before certifying compliance with the state Administrative Procedures Act.

1. As part of the final regulation package, the Department will respond to all comments received during the public comment period concerning the proposed changes.

VIII. DISTINCT PART – LUMP SUM PAYMENT

On or about February 1, 2001, subject to the approval of the Health Care Financing Administration, the State shall pay a one-time lump-sum supplemental payment to each distinct part nursing facility (DP/NF) which received the maximum reimbursement rate for services rendered from August 1, 2000, to January 31, 2001. The amount shall be determined according to the following methodology:

1. DHS will identify the DP/NFs that received the maximum reimbursement rate from August 1, 2000, to January 31, 2001.

2. DHS will estimate the number of days paid to each DP/NF for services provided from August 1, 2000, to January 31, 2001. DHS will use the number of Medi-Cal days paid in calendar year 1999 for each DP/NF, extracted from paid claims data, to develop the estimated days.

3. DHS will determine the proportion of the total Medi-Cal days provided by each DP/NF. The proportion will be determined by dividing the number of Medi-Cal days estimated for each DP/NF by the total of number of Medi-Cal days estimated for all the DP/NFs identified in #1.

4. The lump sum payment for each DP/NF will be calculated by multiplying the proportion calculated in #3 by the total amount to be paid to all DP/NFs. The total amount to be paid will be the amount allocated in the 2000-2001 Budget Act, together with the amount of expected federal reimbursement.

EXAMPLE:

Amount allocated in budget:	$10,700,000 (General Fund)
Federal funds	$10,700,000 (Federal Fund) *
TOTAL FUND	$21,400,000

Estimated total days for all DP/NFs with max. rate	400,000
Days provided by a DP/NF	10,000
Proportion of days (10,000 / 400,000)	.025

Lump sum payment (.025 x $21,400,000)	$535,000

---

* example assumes an FMAP of 50%

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

LONG TERM CARE (LTC) CLASSES TO BE USED FOR RATE-SETTING PURPOSES

PATIENT ACUITY LEVELS	*ORGANIZATION TYPE*	*No. of Beds*	*Geographical Location*	*Reimbursement Basis*
NF LEVEL B	-Distinct part NF	All	Statewide	*
(EXCEPT SUBACUTE,	-Freestanding NF	1-59	Los Angeles Co.	Median
PEDIATRIC SUBACUTE,		1-59	Bay Area**	Median
and TRANSITIONAL		1-59	All Other Counties	Median
INPATIENT CARE		60+	Los Angeles Co.	Median
		60+	Bay Area**	Median
		60+	All Other Counties	Median
SUBACUTE:				
VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	*
	-Freestanding NF	All	Statewide	*
NON-VENTILATOR	-Distinct part NF	All	Statewide	*
DEPENDENT	-Freestanding NF	All	Statewide	*
PEDIATRIC SUBACUTE:				
VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NON-VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
TRANSITIONAL INPATIENT CARE:				
REHABILITATIVE	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
MEDICAL	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NF LEVEL A	-All	1-99	Los Angeles Co.	Median
		1-99	Bay Area**	
		1-99	All Other Counties	Median
		100+	Statewide	***
ICF/DD	-All	1-59	Statewide	65th percentile
		60+	Statewide	65th percentile
ICF/DD-Hs and Ns	-All	4-6	Statewide	65th percentile
		7-15	Statewide	65th percentile
RURAL SWING-BED NF LEVEL B SERVICES	-Rural acute hospitals	All	Statewide	Median

* DP/NF level Bs and Subacute providers are reimbursed at either the lesser of costs as projected by the Department or the prospective median rate of the LTC class.

** Bay area is defined as San Francisco, San Mateo, Marin, Alameda, Santa Clara, and Contra Costa counties.

*** Current rate increased by the same percentage rate as received by other NF level As.

ADD-ONS TO CURRENT RATE METHODOLOGY

- Increase in Licensure Fees - Every July, license fees are modified by the Department's Licensing and Certification Division to reflect the cost of that function. The cost of prior licensing fees are deleted from the projected cost and the new licensing fees are added into the projected cost.

- Minimum Data Set - An amount was added to the rates for skilled nursing facilities, subacute facilities and intermediate care facilities, to cover costs of implementing the Minimum Data Set, which requires all of these facilities to electronically transmit certain long term care data items to the State. This add-on will continue until such costs are reflected in facility cost reports.

- Minimum Wage - An amount was given for freestanding nursing facilities (NF-Bs), intermediate care facilities (NF-As), intermediate care facilities for the developmentally disabled (ICF/DDs), intermediate care facilities for the developmentally disabled-habilitative (ICF/DD-Hs) and intermediate care facilities for the developmentally disabled-nursing (ICF/DD-Ns), to cover the increased salaries, wages and benefits costs incurred by these facilities due to the increase in the federal minimum wage on October 1, 1996, and the increase in the State minimum wage on March 1, 1997. This add-on is described in Long Term Care Minimum Wage Study, report number 01-97-01.

  In addition, components were also added for the federal minimum wage increase effective September 1, 1997, the increase in the California minimum wage which will take effect March 1, 1998. Details of the methodology for these increases are explained in The Long Term Care Minimum Wage Study, report number 01-97-06.

  These add-ons include a component to reimburse the indirect costs of avoiding wage compaction resulting from the minimum wage increases.

  These add-ons will terminate when all costs for the minimum wage increases are reflected in the cost reports.

- Life Quality Assessments - The Department of Developmental Services implemented new legislation requiring assessing and monitoring of clients in ICF/DD, ICF/DD-H and ICF/DD-N facilities to determine the life quality offered to such clients. An amount was added to the 1998-99 rates for these facilities to meet staff costs for these ongoing activities. This add-on will continue until such costs are included in facility cost reports.

- Criminal Background Checks – An add-on to cover costs of rolling and processing fingerprint cards for background checks on direct care staff at ICF/DD and ICF/DD-N facilities. This add-on is described in the Department's report number 01-99-02 and will continue until such costs are reflected the cost reports.

- Bloodborne Pathogen – An add-on to reimburse facilities for a State mandate requiring monitoring and reporting of needlestick injuries and conversion by the industry to new safer needle technology to avoid spread of bloodborne pathogens. This add-on is described in the Department's report number 01-99-03.

- Drug Disposal – This add-on reimburses added costs of transportation and incineration of outdated or leftover drugs and medications. The add-on will continue until such costs are included in the cost reports and the calculation is included in the Department's report number 01-99-06.

- 1999 Wage Pass-Through – An add-on to provide long-term care facilities funding to pass through a wage increase to direct care staff (ie registered nurses, licensed vocational nurses and nurse assistents). The add-on does not apply to transitional care provided by acute care hospitals in their acute beds. This will continue until costs are fully reflected in the cost reports. Details of this add-on are in the Department's report number 01-99-07.

- 2000 Wage Pass-Through – An add-on that provides for all levels of nursing facilities except acute transitional care facilities to pass through a wage increase to all direct and nondirect care staff. Computations are described in the Department's report number 01-00-10.

- Increased Staffing – An add-on to increase reimbursement for level B nursing facilities to provide a minimum of 3.2 hours direct care staffing per patient day. This add-on is described in the Department's report number 01-99-05 (revised).

- Overtime Law Change – This add-on provides reimbursement for a change in the Wage Order of the Industrial Welfare Commission which affects health care providers. The change requires employers to pay overtime pay after 8 hours per day and 40 hours per week. Calculation of this add-on is described in the Department's report number 01-00-06.

- Workers Compensation – An add-on that provides reimbursement for a large industry wide increase in workers compensation rates that has an immediate impact on expenses. The calculation of this add-on is described in the Department's report number 01-00-07.

- Liability Insurance – An add-on to compensate long tern care providers for a recent sharp increase in liability insurance costs for the industry. This increase is described in the Department's report number 01-00-08.

- Elder Abuse Training – An add-on to reimburse the cost of mandated training and documentation of elder and dependent abuse in those facilities serving the elderly. Calculations are described in the Department's report number 01-00-03.

- Day Care Program Oversight – This add-on covers new requirements by the Department of Social Services for all day care programs. The new provisions require ICF/DD, ICF/DD-H and ICF/DD-N providers to oversee their patients that utilize day care programs. A description of this add-on is in the Department's report number 01-00-09.

- Labor Shortage – This add-on compensates long term care facilities that must increase wages to retain and recruit staff because of a labor shortage caused by the current low unemployment rates in California. Calculation of the add-on is described in the Department's report number 01-00-02.

REPORT NO. 01-00-04

REIMBURSEMENT STUDY
FOR
LONG TERM CARE SERVICES

RATE YEAR 2000-2001

Rate Development Branch
Medi-Cal Policy Division
Department of Health Services

July 2000

TN 00-018
Supersedes
TN 99-003

Approval Date APR - 4 2001 Effective Date AUG - 1 2000

DEPARTMENT OF HEALTH SERVICES REPORT

This study establishes Medi-Cal (Medicaid) reimbursement for nursing facilities, including subacute and special treatment program services, intermediate care facilities for the developmentally disabled, including habilitative and nursing services in residential type facilities, as required by Section 249 of Public Law 92-603. The methodology complies with state legislation and the requirements of the Medi-Cal program and California's State Plan.

SUMMARY OF METHODOLOGY

1. Data were collected by staff in the Department's Medi-Cal Policy Division from cost reports submitted by providers to the Office of Statewide Health Planning and Development (OSHPD) and the Department's Financial Audits Branch and were utilized to determine reimbursement by level of care, bedsize class, and geographic area, where applicable.

   In conjunction with this study, the following abbreviations shall apply:

NF-A	Nursing facility - level A (also formerly intermediate care facility - ICF)
NF-B	Nursing facility - level B (also formerly skilled nursing facility- SNF)
DP/NF	Distinct part nursing facility (a nursing facility whose beds are on an acute hospital license - can be level A or B)
ICF/DD	Intermediate care facility for the developmentally disabled
ICF/DD-H	Intermediate care facility for the developmentally disabled-habilitative
ICF/DD-N	Intermediate care facility for the developmentally disabled-nursing
DP	Distinct part
DD	Developmentally disabled

2. In the few instances where nursing facility days were reported separately by level of care, but

the costs were not separated, the total nursing facility days were combined.

3. An audit adjustment, either facility-specific or by class, depending on level of care, reflecting the difference between reported and audited costs and patient days for field audited facilities, was applied to all facilities in the universe. The adjustment included the results of settled appeals.

4. When an ICF/DD-H or N provider erroneously reported calendar days instead of patient days on their cost report, the state contacted the provider and obtained the correct patient day information. This corrected information is used in the rate study.

5. Each facility's adjusted costs were updated from the midpoint of its fiscal reporting period through the midpoint of the State's Medi-Cal rate year, which is January 31, 2001, to bring all costs to a common base period. For this purpose, the reported costs were separated into the categories of (1) fixed or capital-related costs, (2) property taxes, (3) labor costs, and (4) all other costs.

6. A prospective median rate was determined for each category of reimbursement, based on projected costs for each facility. Exceptions were: (a) the state-operated facilities, which receive their actual allowable costs under the provisions of the State Plan; (b) pediatric subacute providers, whose rates are based on a model; (c) the providers of services to all ICF/DD, ICF/DD-H and ICF/DD-N clients, whose rates are set at the prospective 65th percentile in institutions and in residential facilities no larger than 15 beds. Rates above the median were established for DD providers to recognize that they have a disproportionate share of Medi-Cal eligible clients.

METHODOLOGY

Data Collection

The Department receives cost report information from OSHPD on all long term care facilities participating in the Medi-Cal program. These data were used for this study. Some cost data may have been unavailable and, therefore, excluded from the study because facilities either failed to submit a timely report or received permission from OSHPD to file a late report.

Timely reports are rarely excluded from the study, although certain reports may not be useable for rate-setting purposes. Examples include: (1) reports showing no Medi-Cal days, as provided for in

the State Plan, and (2) reports with no allocation of costs to routine cost centers. In addition, DP/NFs with Medi-Cal patient days representing less than 20 percent of the facility's total patient days were excluded from calculation of the median.

All cost reports in the universe had a fiscal reporting period ending in the State's 1998/99 Fiscal Year except for DP/NFs and subacute providers. Cost reports in the DP/NF universe had a fiscal reporting period ending between January 1, 1998 and December 31, 1998. Cost reports in the subacute universe had a fiscal reporting period ending between January 1, 1997 and December 31, 1997. There is no change from the prior year rate methodology for the fiscal period of audit reports used for the subacute program.

After checks for accuracy and completeness, the data were entered into the computer system. Each data record contained the following elements:

1. Provider number
2. Facility name and address
3. An assigned identification number (county code)
4. Licensed bedsize
5. Type of ownership (profit, nonprofit)
6. Fiscal period
7. Total patient days by level of care
8. Total Medi-Cal patient days by level of care
9. Total reported costs by level of care
10. Total plant operations
11. Plant operations by level of care
12. Fixed or capital-related costs
13. Property tax where identified
14. Facility type: freestanding or distinct part of an acute care facility.
15. For subacute providers, patient days for ventilator and non-ventilator patients

If a DP/NF did not file a cost report to be used in the study and/or no audit data for that time period was available, the data used to establish the prior year's projected cost was used to determine the facility's reimbursement rate.

Audit Adjustments

Field audits were performed in accordance with regulations published in Title XVIII of the Social Security Act (Medicare), Title 22 of the California Code of Regulations (CCR), and the California State Plan. The primary audit guidelines came from the Federal Department of Health and

Human Services Manual (HCFA-15).The adjustments, which are based on the findings of field audits, account for the difference between audited and reported costs and patient days. The 2000-2001 rate computations used field audit findings based on reports with fiscal periods ending between July 1, 1998 and June 30, 1999 except for DP/NFs which used reports ending in calendar year 1998.

In accordance with the field audit requirements, the NF-Bs in each of the 1-59 and the 60+ bedsize groups were randomly selected in order to develop the audit adjustments. The sample sizes were large enough to produce audit ratios with a 90 percent confidence that did not deviate by more than 2 percent from the estimated class population. The adjustments were calculated as the ratio of audited to reported costs and patient days. In the case of class audit adjustments, audited costs were modified by a factor reflecting share-of-cost overpayments. The results of settled appeals of audits from prior rate studies were applied to obtain final ratios. The class audit adjustments were:

Bedsize	Ratio
NF-B 1-59	.94503
NF-B 60 +	.97407
ICF/DD-H	.93852
ICF/DD-N	.94603

NF-A Adjustment

The entire universe of NF-As was audited because the small number of facilities was insufficient to create a reliable sample. Facility specific audited costs are used if the fiscal period end of the audit report corresponds with the audit period used in the rate study. A facility-specific audit adjustment was applied to those facilities whose audit report did not correspond. If, for any reason, a field audit was not performed, the average audit adjustment of the peer group was applied.

In the few instances where NF-A and NF-B days were reported separately, but the costs were not, the NF-A and NF-B days were combined.

DP/NF-B and Subacute Adjustment

Actual audited costs were used when the fiscal period of the audit agreed with the fiscal period of the cost report used in the rate study. The NF-B 60+ adjustment was applied to facilities whose audit reports were not final by July 1, 2000.

ICF/DD Adjustment

The entire universe of ICF/DDs was audited because the small number of facilities was insufficient to create a reliable sample. Facility specific audited costs are used if the fiscal period end of the audit report corresponds with the audit period used in the rate study. A facility specific audit adjustment was applied to those facilities whose audit report did not correspond. If, for any reason, a field audit was not performed, the average audit adjustment of the peer group was applied.

ICF/DD-H & ICF/DD-N Audit Adjustment

A sample of ICF/DD-H facilities was audited, and the bedsizes were combined to develop a composite adjustment. A sample of ICF/DD-N facilities was also audited and the bedsizes combined to develop a composite audit adjustment.

Cost-of-Living Update

Adjusted costs for each facility were updated from the midpoint of the facility's report period through the midpoint of the State's Medi-Cal rate year, which is January 31, 2001.

Adjusted costs were divided into categories and treated as follows:

1. Fixed or Capital-Related Costs - These costs represent depreciation, leases and rentals, interest, leasehold improvements, and other amortization. No update was applied.

2. Property Taxes - These costs, where identified, were updated at a rate of 2 percent annually, converted to .1652 percent per month. Some facilities did not report property taxes, either because they were nonprofit and exempt from such tax, or because they had a lease or rental agreement that included those costs.

3. Labor Costs - A ratio of salary, wage, and benefits (SWB) costs to the total costs of each facility was used to determine the amount of the labor cost component to be updated. The ratio was determined by using the overall ratio of salaries and wages to total costs from data extracted by OSHPD from the labor report, and adding costs that represent all wage-related benefits, including vacation and sick leave.

   The final SWB ratios were: .6268 for NF-Bs, .5525 for NF-As, and .6357 for ICF/DDs. The labor costs for ICF/DD-Hs and ICF/DD-Ns are facility-specific, obtained directly from each

cost report in the study. For DP/NFs and subacute providers, a ratio of SWB cost, as described above, to the total cost less fixed and capital related costs was used to determine the amount of labor cost component to be updated. The ratio was .6268. Labor costs for each facility were updated from the midpoint of its cost reporting period to the midpoint of the State's rate year (January 31, 2001). The update tables used industry-specific wage data reported by the facilities as described in the attached Report No. 01-00-01.

4. All Other Costs - These costs are the total costs less fixed or capital-related costs, property taxes, and labor costs. The update for this category utilized the California Consumer Price Index (CCPI) for "All-Urban Consumers" and figures projected by the State Department of Finance through January 31, 2001.

Subacute Services

The subacute rate methodology differs slightly from the regular NF-B and DP/NF-B rate methodology. The differences are that projected costs were developed for ventilator and non-ventilator patients and that additional ancillary costs are included in the cost projections.

The projected cost that was developed for each subacute provider contained the combined costs for ventilator and non-ventilator patients. Subacute providers did not maintain adequate financial records to differentiate the cost difference between ventilator and non-ventilator patient care. The ventilator and non-ventilator costs for each provider were assumed to be the same except for the cost of the ventilator equipment. The provider's total ventilator equipment cost was determined by multiplying the projected ventilator equipment cost by the total ventilator days. This amount was deducted from the total projected cost of the subacute provider to determine the cost of the subacute unit, excluding ventilator equipment cost. The non-ventilator cost was divided by the total patient days to determine the non-ventilator projected cost. The projected ventilator cost was calculated by adding the cost of the ventilator equipment to the non-ventilator projected cost. The data used for ventilator/non-ventilator days were obtained from the following sources in this order; 1) total patient days from the audit reports; 2) Medi-Cal patient days from the audit reports, or 3) Medi-Cal paid claims data for the calendar year of the audit reports used in the rate study. If the data were obtained from 2 or 3, the ratio of ventilator days to non-ventilator days was applied to the total patient days to approximate ventilator and non-ventilator days for the cost report period.

The subacute rate includes additional ancillary costs. Where available, the facility's projected cost was based on the audited ancillary cost data. In the event that audited ancillary costs were not available, the facility's projected cost was based on the median of the projected subacute ancillary

costs of the facilities in the study that had audited ancillary costs.

Pediatric Subacute Services

The model for pediatric subacute provides for therapy evaluations and allows for reimbursement of rehabilitation therapy and ventilator weaning services for qualified patients and some rehabilitation therapy services for patients who do not qualify for this supplement. The model approach continues because of the lack of sufficient reliable pediatric subacute cost data. The detailed description of the model methodology is in a report on file with the State agency.

Adjustment for Changes in Licensure Fees

The updated cost of each facility reflected changes in licensure fees which are modified every July and billed to providers by the Department's Licensing and Certification Division.

Minimum Wage Add-on

An amount was added to facilities' projected costs to compensate for the combined effect of the October 1, 1996 federal and March 1, 1997 State minimum wage increases.

In addition, an amount was added to facilities' projected costs to compensate for the combined impact of the second component of the federal minimum wage increase which was effective September 1, 1997, and the State minimum wage increase which was effective March 1, 1998. A component was also built into the rates to cover the indirect costs of avoiding wage compaction resulting from the minimum wage increases. These add-ons continue until the costs are fully reflected in cost reports used for the rate study.

Minimum Data Set

Reimbursement rates for skilled nursing facilities (NF-Bs), subacute facilities, and intermediate care facilities (NF-As) contain a component to cover the costs of implementing the Minimum Data Set, which requires all of these facilities to electronically transmit certain long term care data items to the State.

Life Quality Assessments

An amount was added to rates to reimburse staff costs for assessing and quarterly monitoring of

clients in ICF/DD, ICF/DD-H and ICF/DD-N facilities to determine the life quality offered to such clients.

Criminal Background Checks

The add-on covers costs of rolling and processing fingerprint cards for background checks on direct care staff in ICF/DD and ICF/DD-N facilities retroactive to April 1, 1999 effective date.

Bloodborne Pathogen

Add-on reimburses facilities for a State mandate requiring monitoring and reporting of needlestick injuries and conversion by the industry to new safer needle technology to avoid spread of bloodborne pathogens.

Drug Disposal

The add-on reimburses added costs of required transportation and incineration of outdated or leftover drugs and medications.

1999 Wage Pass-Through

The add-on provides for freestanding NFs, DP/NFs, subacute facilities and transitional care providers to pass through to direct care staff (ie registered nurses, licensed vocational nurses and nurse assistents) a wage increase. This wage pass-through does not apply to transitional inpatient services which are provided by acute care hospitals in their acute beds.

2000 Wage Pass-Through

The add-on provides for all levels of nursing facilities except acute transitional care facilities to pass through to all direct and nondirect care staff a wage increase.

Increased Staffing

An add-on for the mandated increase in direct care staff to a minimum of 3.2 hours per patient day in level B nursing facilities.

Overtime Law Change

This add-on provides reimbursement for a change in the Wage Order of the Industrial Welfare Commission which affects health care providers. The change requires employers to pay overtime after 8 hours per day and 40 hours per week. This will require employers to pay more overtime for the same number of hours worked.

Workers Compensation

Provides an add-on for a large and unexpected increase in workers compensation rates which followed many years of decline in premiums since the 1995 reforms which sparked competition and plunging premium rates.

Liability Insurance

An add-on to reimburse long term care providers for a sharp increase in liability insurance premiums per licensed bed because of increased losses.

Elder Abuse Training

An add-on to cover the cost of mandated training and documentation of elder and dependent abuse in those facilities serving the elderly.

DD Oversight

The add-on covers new requirements by the Department of Social Services for all day care programs. The new provisions require ICF/DD, ICF/DD-H and ICF/DD-N providers to oversee their patients that utilize day care programs.

Labor Shortage

This add-on compensates long term care facilities because they must increase wages to retain and recruit staff because of the labor shortage which is caused by the current low unemployment rates in California.

Determination of Reimbursement Peer Classes

NF-A and NF-B classes were peer grouped by bedsize, level of care, and three geographical locations: (1) Los Angeles; (2) the six Bay Area counties (Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara); and (3) all other counties. The DP/NF-B class was determined on a statewide basis by level of care, with no bedsize nor geographical grouping.

Classes for ICF/DDs were established on a statewide basis, by bedsize and level of care only, because there was an insufficient number of facilities for geographical grouping. The ICF/DD-H and ICF/DD-N classes were determined on a statewide basis by bedsize only.